

Medical Records

Civil Action Number: 2:17-01146

Claimant: Trish Ann Fontana

Account Number: 197-56-3849

Exhibits

Exhibit No.	Description	Page No.	No. of Pages
4F	Physical/Occupational Therapy Records, dated 10/27/2011 to 11/07/2011, from Jefferson Regional Medical Center	272-278	7
5F	Emergency Department Records, dated 04/07/2010 to 04/17/2013, from UPMC Mercy at South Side Outpatient Center	279-318	40

DATE: April 18, 2018

The documents and exhibits contained in this administrative record are the best copies obtainable.

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Return MAIL or FAX Cover Sheet

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sheet, please place it under this one.

Medical Records
Jefferson Regional Med Ctr
Therapy and Wellness Services
3724 Brownsville Rd
Pittsburgh PA 15227

Re: TRISH A FONTANA
XXX-XX-3849

If responding by mail, put this sheet on top of your response. Use the
enclosed return envelope and ensure that the mailing address appears in
the window.

If responding by FAX, complete the FAX Information section and send to
the FAX Number identified below. Put this sheet on top of your FAX
transmission.

SSA
S67 Greensburg/PA-DDS
PO Box 8751
London, KY 40742-9863



FAX Information
Date: 5/8/13 Time: 2:05 pm Number of Pages, including
this cover sheet: 7
To: Bureau of Disability Determination
Attn: M. Servello Phone Number: 1-800-442-8018
FAX Number: 1-800-358-9954

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*00442149



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BBZZC1

MER - DMAF



RQID:02268926298BZZC1 SITE:S67 DR:S
SSN:197563849 DOCTYPE:0001 RF:D CS:5cf5

60054228 - 4/6



ACCT: 3517370130
 MRN: 490688

FONTANA, TRISH
 RICHMAN, JORY 10/27/2011
 06/02/1967 F 44 THR

Jefferson Regional Medical Center PHYSICAL THERAPY INITIAL EVALUATION

LOCATION

- ☐ JEFFERSON REGIONAL OUTPATIENT SERVICES AT CURRY HOLLOW P: (412) 850-6511 F: (412) 880-9063
☒ JEFFERSON REGIONAL PHYSICAL THERAPY AT THE BRENTWOOD PROFESSIONAL PLAZA P: (412) 886-2727 F: (412) 886-2730
☐ JEFFERSON REGIONAL PHYSICAL THERAPY AND AQUATIC THERAPY P: (412) 469-3456 F: (412) 469-2496
☐ JEFFERSON REGIONAL HEALTH PAVILION P: (412) 854-0190 F: (412) 854-0193

HISTORY OF PRESENT INJURY Pt is a 44 y.o. WF. seen post-op June 30th 2011; dx: HNP.
 Still having LBP.

CHIEF COMPLAINT Pain on R hip down into the lat. thigh. & L lat. thigh pain: Rest: 4-5/10;
 w/ pain meds. ^{post} activity/sitting: 7-8/10. Stiffness in AM. Numbness in heel & 5th digit,
 numbness/tingling R hip / lat-thigh. Cramping B lat-thigh & calves. Diff. sleeping

PAST MEDICAL HISTORY Recent LB sx. June 2011. LBP & neck pain

PREVIOUS LEVEL OF FUNCTION Light walking. Doing laundry. Doing all homemaking, drive,
 in w/ ADLs/walking.

MEDICATIONS Motrin / Advil ~ Percocet w/ severe pain

GENERAL OBSERVATIONS Very slow pace, guarded stance/gait - stiff

POSTURE normal

RANGE OF MOTION

STRENGTH:

R hip Flex: 100% R hip ABD: 100%

L hip Flex: 40/5, L hip ABD: 4/5

L hip Flex: 25-50% ^{25-50%} _{ACOM} L hip ABD: 50% _{ACOM}

R hip Flex: 2/5, R hip ABD: 2/5

R hip ER: 25° IR: 10° AROM

WLE Knee/ankle: 5/5

L hip ER: 40° IR: 20° AROM

R knee /: 3/5, R knee √: 40/5

distal Bil LES: AROM WFL

L knee √ & /: 4/5

R dors / plant Flex: 5/5

Lumbar Flex: 50° Ext: 25°

R Rotation: 50% (tightness) L: 75% AROM

Weak core muscles / ABDs.

R SB: 50-75% tightness L: 50-75% tightness pulls w/ R





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Jefferson Regional Medical Center PHYSICAL THERAPY INITIAL EVALUATION

PALPATION No pain w/ palpation.

SPINAL/PELVIC DYSFUNCTIONS FABER ⊖ Bil; SLR ⊖ B but tight hamstring; ⊕ uses (B) (R) & L passive SLR 2+ to weakness/tightness

SPECIAL TESTS ✓ PSIS, ASIS symmetrical ⊖ SI Compression/distraction.

NEUROVASCULAR STATUS sensation intact (B) LES.

BALANCE good

GAIT/STAIRS antalgic, guarded, slow pace & small stride/step length (Indep no dev.)

FUNCTIONAL DEFICITS/TRANSFERS : Indep. (antalgic)

PROBLEMS ① ↑ LAD, ② hips/knights (B) & L ③ ↓ Flexibility ④ ↓ ROM/LE ⑤ ↓ activity level ⑥ LE weakness ⑦ XE

ASSESSMENT Post-op. Back sx w/ pain, weakness, ↓ ROM/flexibility.

PATIENT STATED GOALS Full activity w/o restriction & no pain (a) sleep disturbances

PLAN OF CARE Frequency: 2X/WEEK Duration: 4-6 weeks

☒ Modalities ☒ Therapeutic procedures ☐ Aquatic Therapy ☐ Neuromuscular reeducation ☐ Other Stretching
☐ Manual therapy ☐ Functional activities ☐ Balance ☐ Gait Strengthening
pt education
stabilization

SHORT TERM GOALS (4 WEEKS) 2-4 wks 1) ↓ pain to 2-3/10 w/ activity 2) ↑ walking to 1 mile
3) Indep w/ HEP. 4) ↑ Flex Lumbar by 20° 5) Indep SLR (B) X10 REPS.

LONG TERM GOALS (6-8 WEEKS) 4-6 wks 1) ↓ pain to 0-1/10 w/ activity 2) ↑ walking to 1.2 miles
3) Retain all activities w/o restrictions 4) Hip Flex/ABD: 40/55 5) Full ROM SB & rotation
b) ↑ Flex by 25-50%.

COMMENTS

☒ Findings, plan of care and goals explained to the patient/family ☒ Patient educated
☒ Patient verbally agreed to stated plan of care and goals ☐ Initiated treatment
☒ Patient treatment program initiated, please refer to charted note and flow sheet

REHABILITATION POTENTIAL

☐ Guarded ☐ Poor ☐ Fair ☒ Good ☐ Excellent

If Guarded, poor or fair explain:

MEDICARE PATIENTS ONLY

SERVICE DATE: FROM: THROUGH:

Thank you for your referral of this patient to Jefferson Regional Medical Center. If you have any questions or comments regarding this patient's treatment, please do not hesitate to contact me. Please sign and return to act as a prescription to continue physical therapy services.

SIGNATURE/ DATE Michael Keckley DPT 10-27-11

MD SIGNATURE/ DATE Please Sign





ACCT: 3517370130
MRN: 490688

FONTANA, TRISH
RICHMAN, JORY 10/27/2011
06/02/1967 F 44 THR

Jefferson Regional Medical Center OUTPATIENT PHYSICAL THERAPY DAILY TREATMENT NOTE

VISIT #	20111111	DATE	10-27-11	START	12:45	END	1:45	SIGNATURE	Michelle M. Kallala DPT
SUBJECTIVE: Pain Self-Report of Pain <u> </u> /10 <input type="checkbox"/> No New Complaints <input type="checkbox"/> Communications: <u> </u>									
<input type="checkbox"/> Patient Reports: <u>Refer to P.T. Eval.</u>									
OBJECTIVE: <input type="checkbox"/> Functional: <u> </u> <input type="checkbox"/> ROM: <u> </u>									
<input type="checkbox"/> Strength: <u> </u>									
<input type="checkbox"/> Other: <u> </u> <input type="checkbox"/> Modalities and Therapeutic Activities/Procedures Completed as Per Treatment Flow Sheet.									
<input type="checkbox"/> Manual Techniques Completed Per Flow Sheet <input type="checkbox"/> New Manual Techniques: <u> </u>									
<input checked="" type="checkbox"/> New Exercises: <u>piriformis stretch, hamstring stretch, IT band stretch 12 reps @ 20 sec.</u>									
<input checked="" type="checkbox"/> New Modalities: <u>demonstrated gastroc & bridges x3</u>									
ASSESSMENT: <input type="checkbox"/> Progress Towards Goals: <u>Understood HEP; issued written HEP.</u>									
<input type="checkbox"/> Remaining Deficits: <u> </u>									
PLAN: <input checked="" type="checkbox"/> Continue With Progression of the Current Plan of Care <input type="checkbox"/> Discontinue Skilled Therapy Services <u>2x/week</u>									
<input type="checkbox"/> Modifications to Plan of Care: <u> </u> Frequency/Duration: <u> </u>									
Modalities: <u> </u>									
Therapeutic Activities/Exercises: <u> </u>									
Other: <u> </u>									

TREATMENT (TIME/UNITS):									
<input type="checkbox"/> Aquatic Therapy	<input type="checkbox"/> Manual Therapy	<input type="checkbox"/> Massage	<input type="checkbox"/> Gait Training						
<input type="checkbox"/> Therapeutic Activity/Functional Exercise	<input type="checkbox"/> Electrical Stimulation (Attended)	<input type="checkbox"/> Electrical Stimulation (Unattended)	<input type="checkbox"/> Neuromuscular Re-education						
<input type="checkbox"/> Iontophoresis	<input type="checkbox"/> Ultrasound	<input checked="" type="checkbox"/> Evaluation	<input type="checkbox"/> Mechanical Traction						
<input checked="" type="checkbox"/> Therapeutic Exercise	<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Whirlpool	<input type="checkbox"/> Re-evaluation						
<input type="checkbox"/> Transcutaneous Neurostimulation	<input type="checkbox"/> Modal Hot/Cold Pack	<input type="checkbox"/> Other							

VISIT #	2	DATE	10-31-11	START	1:30	END	1:55	SIGNATURE	Michelle M. Kallala DPT
SUBJECTIVE: Pain Self-Report of Pain <u> </u> /10 <input type="checkbox"/> No New Complaints <input type="checkbox"/> Communications: <u> </u>									
<input checked="" type="checkbox"/> Patient Reports: <u>Feeling better. IT band & piriformis hurt. Wanting to continue with piriformis stretch.</u>									
OBJECTIVE: <input type="checkbox"/> Modalities and Therapeutic Activities/Procedures Completed as Per Treatment Flow Sheet. <input type="checkbox"/> Manual Techniques Completed Per Flow Sheet									
<input type="checkbox"/> Changes to Program: <u>piriformis stretch x20 (no pain); hamstring stretch x20 sec @ 20; gastroc stretch x3; bridges x20; lung sit x15;</u>									
<input checked="" type="checkbox"/> Measurements: <u>piriformis 30x20 sec; gastroc 15 sec @ 10; quadriceps x10 @ 10 w/ RTA. (CMT) no pain issues to be in peace.</u>									
ASSESSMENT: <input type="checkbox"/> Patient Progressing Towards Goal: <input type="checkbox"/> Other <u> </u>									
<input type="checkbox"/> Remaining Deficits: <u> </u>									
PLAN: <input type="checkbox"/> Continue With Progression of the Current Plan of Care <input type="checkbox"/> Other <u> </u>									

TREATMENT (TIME/UNITS):									
<input type="checkbox"/> Aquatic Therapy	<input type="checkbox"/> Manual Therapy	<input type="checkbox"/> Massage	<input type="checkbox"/> Gait Training						
<input type="checkbox"/> Therapeutic Activity/Functional Exercise	<input type="checkbox"/> Electrical Stimulation (Attended)	<input type="checkbox"/> Electrical Stimulation (Unattended)	<input type="checkbox"/> Neuromuscular Re-education						
<input type="checkbox"/> Iontophoresis	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Evaluation	<input type="checkbox"/> Mechanical Traction						
<input checked="" type="checkbox"/> Therapeutic Exercise	<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Whirlpool	<input type="checkbox"/> Re-evaluation						
<input type="checkbox"/> Transcutaneous Neurostimulation	<input type="checkbox"/> Modal Hot/Cold Pack	<input type="checkbox"/> Other							

VISIT #	3	DATE	11-3-11	START	1:35	END	1:55	SIGNATURE	Michelle M. Kallala DPT
SUBJECTIVE: Pain Self-Report of Pain <u> </u> /10 <input type="checkbox"/> No New Complaints <input type="checkbox"/> Communications: <u> </u>									
<input checked="" type="checkbox"/> Patient Reports: <u>in pain. feeling much better & loose.</u>									
OBJECTIVE: <input type="checkbox"/> Modalities and Therapeutic Activities/Procedures Completed as Per Treatment Flow Sheet. <input type="checkbox"/> Manual Techniques Completed Per Flow Sheet									
<input checked="" type="checkbox"/> Changes to Program: <u>piriformis stretch x20 sec; bridges 7x20 sec; sit-ups (wall sit) x10; squats 2x at 10 sec x10; wall sit x10;</u>									
<input type="checkbox"/> Measurements: <u>piriformis x10 @ 10; gastroc 15 sec @ 10; quadriceps x10 @ 10 w/ RTA. (CMT) no pain issues to be in peace.</u>									
ASSESSMENT: <input type="checkbox"/> Patient Progressing Towards Goal: <input type="checkbox"/> Other <u> </u>									
<input type="checkbox"/> Remaining Deficits: <u> </u>									
PLAN: <input type="checkbox"/> Continue With Progression of the Current Plan of Care <input type="checkbox"/> Other <u> </u>									

TREATMENT (TIME/UNITS):									
<input type="checkbox"/> Aquatic Therapy	<input type="checkbox"/> Manual Therapy	<input type="checkbox"/> Massage	<input type="checkbox"/> Gait Training						
<input type="checkbox"/> Therapeutic Activity/Functional Exercise	<input type="checkbox"/> Electrical Stimulation (Attended)	<input type="checkbox"/> Electrical Stimulation (Unattended)	<input type="checkbox"/> Neuromuscular Re-education						
<input type="checkbox"/> Iontophoresis	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Evaluation	<input type="checkbox"/> Mechanical Traction						
<input checked="" type="checkbox"/> Therapeutic Exercise	<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Whirlpool	<input type="checkbox"/> Re-evaluation						
<input type="checkbox"/> Transcutaneous Neurostimulation	<input type="checkbox"/> Modal Hot/Cold Pack	<input type="checkbox"/> Other							





FONTANA, TRISH
RICHMAN, JORY 10/27/2011
06/02/1967 F 44 THR

ACCT: 3517370130
MRN: 490688

Jefferson Regional Medical Center
**PHYSICAL THERAPY
PROGRESS NOTE**

LOCATION	
<input type="checkbox"/> JEFFERSON REGIONAL OUTPATIENT SERVICES AT CURRY HOLLOW	P: (412) 650-6511 F: (412) 650-9063
<input type="checkbox"/> JEFFERSON REGIONAL PHYSICAL THERAPY AND AQUATIC THERAPY	P: (412) 469-3456 F: (412) 469-2495
<input checked="" type="checkbox"/> JEFFERSON REGIONAL PHYSICAL THERAPY AT THE BRENTWOOD PROFESSIONAL PLAZA	P: (412) 886-2727 F: (412) 886-2730
<input type="checkbox"/> JEFFERSON REGIONAL HEALTH PAVILION	P: (412) 854-0190 F: (412) 854-0193
GENERAL INFORMATION	
TO <u>Dr. Richman</u>	FROM <u>Nicole M Reilly, DPT</u> DATE <u>11-7-11</u>
PATIENT'S NAME <u>Trish Fontana</u>	DIAGNOSIS <u>post op microdiscectomy L5-S1</u>
This patient was initially evaluated on <u>10-27-11</u> and has been receiving treatment <u>4</u> times per week over the past <u>2</u> weeks.	
SUBJECTIVE	
<u>Pt reported pain initially (R) > (L); w/ activity 7-8/10. Now 3-5/10, no pain on (R) but, intermittent stabbing (L) L5-S1 & buttock pain w/ activity.</u>	
OBJECTIVE	
ROM (11-7-11) Flex: 80° (L) SB: 100% (tight/pain) (L) Rot: 75° w/o pain (R) Hip Flex/ASD: 4/5	Ext: 30° (R) SB: 100% (L) Rot: 100% pain (L) Hip Flex/ASD: 3/5
STRENGTH (R) ER/IR: 45°/40° (L) ER/IR: 40°/20° (pain) (L) Clitully, BLES: 4/5	
POSTURE	
SPECIAL TESTS (B) FABER ⊖; SLR ⊖ (B); (+) OBERS (B); ⊖ SI Comp destruction; tight hamstrings (B)	
GAIT/FUNCTION <u>Slight limp on (L) side 20 to pain (Antalgic)</u>	
NEUROVASCULAR (B) Feet burning/tingling & Cramping calves.	
PHYSICAL THERAPY ASSESSMENT	
<u>Pt seen initially w/ moderate-severe ↓ Flexibility & pain (R) > (L); now (L) sided L&T only.</u>	
TREATMENT PLAN/UPDATED GOALS	
FREQUENCY <u>2x/week</u>	DURATION <u>2-4 weeks:</u>
<u>Pt will continue w/ PT for stretching, modalities PWD, pt. education, stabilization & strengthening. Cont w/ PT to meet goals indicated on P.T eval 10-27-11</u>	
REHABILITATION POTENTIAL	
<u>Good</u>	
MEDICARE PATIENTS ONLY	
SERVICE DATE: FROM:	THROUGH:
Thank you for your referral of this patient to Jefferson Regional Medical Center. If you have any questions or comments regarding this patient's treatment, please do not hesitate to contact me. Please sign and return to act as a prescription to continue physical therapy services.	
SIGNATURE/ DATE <u>Trish Fontana</u>	SIGNATURE/ DATE <u>Nicole M Reilly DPT</u> <u>Please Sign</u>



ACCT: 3517370130
MRN: 490688

FONTANA, TRISH
RICHMAN, JORY 10/27/2011
06/02/1967 F 44 THR

Jefferson Regional Medical Center OUTPATIENT PHYSICAL THERAPY DAILY TREATMENT NOTE

VISIT #	DATE	START	END	SIGNATURE
4	11-7-11	1650	1745	Michelle M. Rally DPT
SUBJECTIVE: Pain Self-Report of Pain <u>10</u> <input type="checkbox"/> No New Complaints <input type="checkbox"/> Communications: _____ <input type="checkbox"/> Patient Reports: <u>Refer to Progress note</u>				
OBJECTIVE: <input type="checkbox"/> Functional: <u>↓</u> <input type="checkbox"/> ROM: <u>↓</u> <input type="checkbox"/> Strength: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Modalities and Therapeutic Activities/Procedures Completed as Per Treatment Flow Sheet.				
<input type="checkbox"/> Manual Techniques Completed Per Flow Sheet <input type="checkbox"/> New Manual Techniques: _____ <input type="checkbox"/> New Exercises: <u>15 min @ 5x20sec - det; 50 to 10 min to stretch w/6 wts.</u> <input type="checkbox"/> New Modalities: <u>Sit to 10 min 4x30sec</u>				
ASSESSMENT: <input type="checkbox"/> Progress Towards Goals: <u>A demonstrates possible source on L, 1 par. sitting on buttock</u> <input type="checkbox"/> Remaining Deficits: <u>1 pt. ex hit pelvic w/ flex stretches in spine. (? neural glide)</u>				
PLAN: <input checked="" type="checkbox"/> Continue With Progression of the Current Plan of Care <input type="checkbox"/> Discontinue Skilled Therapy Services <input type="checkbox"/> Modifications to Plan of Care: _____ Frequency/Duration: _____ Modalities: _____ Therapeutic Activities/Exercises: _____ Other: <u>modified HEP; defn ext. ex. Follow.</u>				

TREATMENT (TIME/UNITS):	<input type="checkbox"/> Aquatic Therapy	<input type="checkbox"/> Manual Therapy	<input type="checkbox"/> Massage	<input type="checkbox"/> Gait Training
<input type="checkbox"/> Therapeutic Activity/Functional Exercise	<input type="checkbox"/> Electrical Stimulation (Attended)	<input checked="" type="checkbox"/> Electrical Stimulation (Unattended) <u>15/1</u>	<input type="checkbox"/> Neuromuscular Re-education	<input type="checkbox"/> Transcutaneous Neurostimulation
<input type="checkbox"/> Iontophoresis	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Evaluation	<input type="checkbox"/> Mechanical Traction	<input type="checkbox"/> Modal Hot/Cold Pack
<input checked="" type="checkbox"/> Therapeutic Exercise <u>40/3</u>	<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Whirlpool	<input type="checkbox"/> Re-evaluation	<input type="checkbox"/> Other

VISIT #	DATE	START	END	SIGNATURE
SUBJECTIVE: Pain Self-Report of Pain _____/10 <input type="checkbox"/> No New Complaints <input type="checkbox"/> Communications: _____ <input type="checkbox"/> Patient Reports: _____				
OBJECTIVE: <input type="checkbox"/> Modalities and Therapeutic Activities/Procedures Completed as Per Treatment Flow Sheet. <input type="checkbox"/> Manual Techniques Completed Per Flow Sheet <input type="checkbox"/> Changes to Program: _____ <input type="checkbox"/> Measurements: _____				
ASSESSMENT: <input type="checkbox"/> Patient Progressing Towards Goal: <input type="checkbox"/> Other _____ <input type="checkbox"/> Remaining Deficits: _____				
PLAN: <input type="checkbox"/> Continue With Progression of the Current Plan of Care <input type="checkbox"/> Other _____				

TREATMENT (TIME/UNITS):	<input type="checkbox"/> Aquatic Therapy	<input type="checkbox"/> Manual Therapy	<input type="checkbox"/> Massage	<input type="checkbox"/> Gait Training
<input type="checkbox"/> Therapeutic Activity/Functional Exercise	<input type="checkbox"/> Electrical Stimulation (Attended)	<input type="checkbox"/> Electrical Stimulation (Unattended)	<input type="checkbox"/> Neuromuscular Re-education	<input type="checkbox"/> Transcutaneous Neurostimulation
<input type="checkbox"/> Iontophoresis	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Evaluation	<input type="checkbox"/> Mechanical Traction	<input type="checkbox"/> Modal Hot/Cold Pack
<input type="checkbox"/> Therapeutic Exercise	<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Whirlpool	<input type="checkbox"/> Re-evaluation	<input type="checkbox"/> Other

VISIT #	DATE	START	END	SIGNATURE
SUBJECTIVE: Pain Self-Report of Pain _____/10 <input type="checkbox"/> No New Complaints <input type="checkbox"/> Communications: _____ <input type="checkbox"/> Patient Reports: _____				
OBJECTIVE: <input type="checkbox"/> Modalities and Therapeutic Activities/Procedures Completed as Per Treatment Flow Sheet. <input type="checkbox"/> Manual Techniques Completed Per Flow Sheet <input type="checkbox"/> Changes to Program: _____ <input type="checkbox"/> Measurements: _____				
ASSESSMENT: <input type="checkbox"/> Patient Progressing Towards Goal: <input type="checkbox"/> Other _____ <input type="checkbox"/> Remaining Deficits: _____				
PLAN: <input type="checkbox"/> Continue With Progression of the Current Plan of Care <input type="checkbox"/> Other _____				

TREATMENT (TIME/UNITS):	<input type="checkbox"/> Aquatic Therapy	<input type="checkbox"/> Manual Therapy	<input type="checkbox"/> Massage	<input type="checkbox"/> Gait Training
<input type="checkbox"/> Therapeutic Activity/Functional Exercise	<input type="checkbox"/> Electrical Stimulation (Attended)	<input type="checkbox"/> Electrical Stimulation (Unattended)	<input type="checkbox"/> Neuromuscular Re-education	<input type="checkbox"/> Transcutaneous Neurostimulation
<input type="checkbox"/> Iontophoresis	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Evaluation	<input type="checkbox"/> Mechanical Traction	<input type="checkbox"/> Modal Hot/Cold Pack
<input type="checkbox"/> Therapeutic Exercise	<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Whirlpool	<input type="checkbox"/> Re-evaluation	<input type="checkbox"/> Other



movit: 119-11

FONTANA, TRISH
RICHMAN, JORY 10/27/2011
06/02/1967 F 44 THR

PATIENT'S NAME _____

DIAGNOSIS

post-up. LG-S, microdissection

[illegible]

JEFFERSON
REGIONAL MEDICAL CENTER

EXERCISE PROGRESSION RECORD



RHO120

ED Evaluation Note-Mercy:

University of Pittsburgh Medical Center

Patient: **FONTANA, TRISH A** MRN: **980404528** FIN: **0334426883107**
Age: **45 years** Sex: **Female** DOB: **6/2/1967**
Associated Diagnoses: **None**
Author: **CONOVER, KEITH**

Visit Information

Visit Information: Patient seen on 4/17/2013.

Findings

ATTENDING EMERGENCY MEDICINE NOTE:

Registration clerk chief complaint reviewed. Agree

Triage note reviewed. Agree

CHIEF COMPLAINT: Right neck pain, weakness in hands, tingling in the legs

History of Present Illness: The patient is a 45-year-old woman, smoker, past medical history of some chronic low back pain which is not a current complaint, did have surgery for an L5-S1 disc 2 years ago, also a history of about a year of undiagnosed rash on her right cheek despite seeing dermatology, here with a chief complaint of 2 weeks of progressive worsening of pain in the right more than left neck, associated with a decreased range of motion there, and some mild bilateral hand weakness, as well some intermittent tingling in both legs. No saddle anesthesia, no problems with urination or defecation. The pain is moderate, dull and aching. Does not want any pain medication for it at this time.

REVIEW OF SYSTEMS: All systems listed below were reviewed and are negative unless otherwise noted in the report.

General

EYES

ENT

Cardiac

Respiratory

Gastrointestinal

Genitourinary

Musculoskeletal

Dermatologic

Neurological

Allergic/Immunologic

PAST MEDICAL HISTORY: As above

MEDICATIONS: Reviewed and agree with Nursing Notes

ALLERGIES: Reviewed and agree with Nursing Notes

SOCIAL HISTORY: As above

PHYSICAL EXAM: Vital Signs: reviewed nurses' note

PATENT STATUS: alert, cooperative, mild distress, holding her neck quite still, not ill appearing, well-hydrated

EYES: PERRL, EOMI, no injection, anicteric.

THROAT: No injection. No exudate. No tonsillar hypertrophy. Airway widely patent. Uvula is midline. No tonsillar bulging, retropharyngeal soft tissues appear normal.

NECK: Range of motion is decreased. Moderate right more than left spasm but minimal tenderness. No palpable adenopathy. No midline tenderness.

BACK: No costovertebral, paravertebral, intravertebral or prevertebral tenderness or spasm.

CHEST: nontender, normal expansion, no retractions.

LUNGS: Clear to auscultation and percussion. No rales. No rhonchi. No rubs. No wheezes.

HEART: Regular rate and rhythm, no murmurs rubs or gallops.

ABDOMEN: Soft, nontender, normal bowel sounds, no guarding or rebound, no hepatosplenomegaly or mass, no bruit.

SKIN: Warm, dry, no cyanosis, no petechiae. There is a 4 cm circular erythematous lesion on the right cheek with some central fine scaling however no palpable adenopathy proximal to this.

EXTREMITIES: No edema. No cyanosis. No clubbing. No calf tenderness.

NEUROLOGICAL: Alert. Cooperative. Sensory and motor functions are intact except for some mild weakness of hand grip bilaterally, difficult to rate but probably a bit less than her normal.

MEDICAL DECISION MAKING/DIFFERENTIAL DIAGNOSIS: Old records reviewed. This scenario it is very concerning for possible spinal stenosis in the cervical spine, so obtained an MRI; no IVDA, no recent fever, no palpable adenopathy, not particularly suspicious of cancer or infection, so the MRI was without contrast. This did show a large herniated disc at C4-5 with indentation of the spinal cord. Given her symptoms, and this finding, I immediately contacted Dr. Blackrick on call for her orthopedic surgeon, Dr. Richman. We agreed on a Medrol Dosepak, Tylenol and Flexeril, and she will keep her appointment with him on Monday. Cautioned to return to ED if worse weakness in hands or any new or worsening symptoms. Recommended gentle neck stretching.

DIAGNOSIS: Acute herniated cervical disc with spinal stenosis and motor weakness in the hands.

DISPOSITION: Patient discharged in stable condition. Computer-generated discharge instructions provided.

Professional Services

Credentials Title and Author

Credentials: MD.

Title: Attending.

Perform - Completed by CONOVER, KEITH (on 04/17/2013 15:29)

Sign - Completed by CONOVER, KEITH (on 04/17/2013 15:29)

VERIFY - Completed by CONOVER, KEITH (on 04/17/2013 15:29)

*** RADIOLOGY REPORT ***

Patient Name: FONTANA, TRISH A DOB: 06/02/1967
MRN: 980404528 Gender: F Location: UDEM (MCY)
Exam Desc: MR SPINE CERVICAL WITHOUT CONTRAST

Accession Date: 04/17/2013 13:29
Dictated on : 04/17/2013 15:37

Attending MD: KEITH CONOVER

Requesting MD: KEITH CONOVER

Accession #: 70217036

Visit Number: 0334426883107

Attending Interpreter: KHURSHED J DASTUR

Assisting Interpreter: BENJAMIN C JACOBS

*** FINAL REPORT ***

Reason for the Exam:

? cord compression: R neck pain 2 wks, weakness in hands, numbness in legs
CLINICAL HISTORY: 45-year-old woman with right neck pain and leg and arm weakness for 2 weeks.

TECHNIQUE:

Multiecho multiplanar MR imaging of the cervical spine was performed without intravenous contrast. Sequences include 3 plane localizer, sagittal T1, sagittal STIR, sagittal T2, axial T2 stack, axial gradient, and axial T1.

COMPARISON:

None.

FINDINGS:

There is mild straightening of the normal cervical lordosis and possible mild smooth kyphosis, centered at C4-C5. Bony alignment is anatomic and there is no evidence of acute fracture. Mild disc space narrowing is most significant at C5-C6. The craniocervical junction is unremarkable. Paravertebral soft tissues appear normal. Vertebral artery flow voids are preserved.

Degenerative changes are most significant at C4-C5 where a posterior disc osteophyte complex impresses upon and mildly distorts the ventral aspect of the cervical cord. There is no definite associated cord signal abnormality to suggest edema. The spinal canal and neural foramina are patent at all other imaged levels.

IMPRESSION:

Degenerative changes most significant at C4-C5 where a posterior disc osteophyte complex impresses upon and distorts the ventral aspect of the cord.

Degenerative narrowing of C5-6 disc space.

RELEVANT CLINICAL INFORMATION: ? cord compression: R neck pain 2 wks, weakness in hands, numbness in legs

Dictated by: KHURSHED J DASTUR

Signed by: KHURSHED J DASTUR

Signed on: 04/17/2013 at 3:37 PM

<<< PAGE 1 >>>

*U*P*M*C* FONTANA, TRISH Acct#:0334426881363

UPMC MERCY
PAIN SERVICE
OPERATIVE REPORT

PATIENT NAME: FONTANA, TRISH A
ACCOUNT #: 0334426881363
SURGEON: Gregg G. Weidner, M.D.
ATTENDING PHYSICIAN: GREGG WEIDNER
SURGERY DATE: 01/12/12
ADMISSION DATE: 01/12/2012
DISCHARGE DATE:

HISTORY:

Trish returns to see me. The patient complains of back pain with some tingling going down her legs. The patient denies any weakness. The patient had trialed the Neurontin which she does think it has been helpful, but she has been reluctant to take it _____ possible side effects. She has been taking Vicodin, but she has been out of Vicodin for some time. The patient today did undergo repeat lumbar epidural steroid injection which was well tolerated.

PROCEDURE NOTE:

With informed consent, the patient was placed in the prone position. Chloraprep was applied in a wide and thorough prep. Then Betadine was applied. Sterile draping was utilized. Skin infiltration was performed with 5 mL of 1% lidocaine. Then under fluoroscopic guidance, an 18-gauge Tuohy needle was advanced into the interlaminar epidural plane. No heme or CSF was aspirated. Methylprednisolone was then drawn up sterilely and injected 80 mg in a volume of 2 mL preservative saline. Needle tract was cleared.

The patient tolerated this well. The patient was given a prescription for short supply of Vicodin. I discussed these issues thoroughly with patient.

Authenticated electronically at end of document

Dictator: Gregg G. Weidner, M.D.

GGW/dn

D: 01/12/2012 09:40:32
T: 01/12/2012 17:26:15
R: 01/12/2012 17:26:15/dn
43436957/3833496/39750353

CC:

Authenticated by GREGG G WEIDNER, MD On 01/18/2012 07:13:57 AM

*U*P*M*C* FONTANA, TRISH Acct#:0334426881334

UPMC MERCY
PAIN SERVICE
OPERATIVE REPORT

PATIENT NAME: FONTANA, TRISH A
ACCOUNT #: 0334426881334
SURGEON: Gregg G. Weidner, M.D.
ATTENDING PHYSICIAN: GREGG WEIDNER
SURGERY DATE: 12/09/11
ADMISSION DATE: 12/09/2011
DISCHARGE DATE:

DATE OF BIRTH:

06/02/1967

HISTORY OF PRESENT ILLNESS:

Ms. Fontana is a very pleasant lady who presents to me at Dr. Richman's request. The patient has a history of a previous lumbar laminectomy at L5-S1 with Dr. Richman. In June 2011, she had the significant pain down the right leg at that time and was found to have a large disk herniation with compression of the S1 nerve root. She tolerated the surgery well and initially saw significant improvement in her leg pain, but now has seen persistent low back pain with some pain traveling into her legs, but not in the same fashion as it had prior to surgery. The patient also complains of some degree of neck pain and pain into the arms. She notes that activity seems to exacerbate her pain. She gets crampy in her legs. She feels shooting pain into the _____ feet. The patient cannot exercise for any significant length of time secondary to pain. She cannot sit for a long time. The patient has been taking Vicodin twice a day for the pain as well as ibuprofen and Prilosec. The patient has no bowel or bladder incontinence. She has had no falls, no trauma. The patient denies any headaches.

REVIEW OF SYSTEMS:

The patient's review of systems is otherwise negative aside from joint pains, stiffness, and muscle aches. Her review of system is negative for constitutive, visual, ear, nose, and throat, respiratory, cardiovascular, musculoskeletal, dermatologic, immunologic, hematologic, lymphangitic, genitourinary, gynecologic, psychiatric, and psychologic.

FAMILY HISTORY:

The patient's family history is significant for father having hypertension, diabetes, coronary artery disease and end-stage renal failure. Her mother has hypertension.

PAST SURGICAL HISTORY:

The patient's past surgical history includes:
1. Pilonidal cyst operation.

*U*P*M*C* FONTANA, TRISH Acct#: 0334426881334

2. She has also had podiatric surgery in addition to lumbar spinal surgery.

ALLERGIES:

THE PATIENT IS ALLERGIC TO:

1. PENICILLIN.
2. PENTOTHAL.
3. MORPHINE.
4. THE PATIENT ALSO IS ALLERGIC TO DIFFERENT TYPES OF TAPE.

SOCIAL HISTORY:

The patient is a smoker. Denies any alcohol consumption. Denies any history of IV drug abuse.

PHYSICAL EXAMINATION:

VITAL SIGNS: The patient's examination shows she is 5 feet 3 inches, 158 pounds, her blood pressure is 149/94, and she is afebrile. GENERAL: She is able to stand and ambulate. She has no weakness in the upper and lower extremities. HEENT: The patient has no adenopathy, no thyroid enlargement. The patient had normal pupils. Tongue was midline. Cranial nerves were intact. LUNGS: Clear to auscultation anterior and posterior. CARDIOVASCULAR EXAMINATION: Regular without any murmur. ABDOMEN: Obese. There was no guarding or rigidity. Had normoactive bowel sounds. MUSCULOSKELETAL: She was not tender to palpation of the cervical, thoracic, or lumbar spine. The patient had normal reflexes in upper and lower extremities and symmetrically so. Her strength is 5/5 in upper and lower extremities. SKIN: Dry and warm. NEUROLOGIC: There was no allodynia. She had normal sensation. Her pulses were normal. There was no peripheral edema. The patient had pain with straight leg raising in the back, but no radicular component pain. She had good range of motion of the hip and the knee. Her gait was normal without any ataxia.

I did review the MRI of the lumbar spine, which was done here at UPMC Mercy Hospital. It was available on the Stentor System.

The patient had a disk bulge at L4-L5 with spondylolisthesis at that level or an anterolisthesis at that level and some neuroforaminal stenosis. She had scar at L5-S1.

After discussing with the patient thoroughly the risks and benefits, today I did perform a lumbar epidural steroid injection, which was well tolerated.

PROCEDURE NOTE:

With informed consent, the patient was placed in the prone position. Chloraprep was applied in a wide and thorough prep. This was allowed to completely dry. Then, Betadine was applied. Sterile draping was utilized. Skin infiltration was performed with 5 mL of 1% lidocaine. Then, under fluoroscopic guidance, an 18-gauge Tuohy needle was advanced into the interlaminar epidural plane. No heme or CSF was aspirated. Methylprednisolone was then drawn up sterilely and instilled 80 mg in a volume of 2 mL preservative-free saline. Needle tract was cleared. The patient tolerated

*U*P*M*C* FONTANA, TRISH Acct#:0334426881334

this well. The patient was given prescriptions for tramadol and Neurontin, and was given a return appointment.

Authenticated electronically at end of document

Dictator: Gregg G. Weidner, M.D.

GGW/sn

D: 01/12/2012 07:58:00

T: 01/12/2012 11:51:33

R: 01/12/2012 11:51:33/sn

43435127/3833218/39745049

CC:

Authenticated by GREGG G WEIDNER, MD On 01/18/2012 07:10:08 AM

*** RADIOLOGY REPORT ***

Patient Name: FONTANA, TRISH A DOB: 06/02/1967
MRN: 980404528 Gender: F Location: URAD (MCY)
Exam Desc: MR SPINE LUMBAR WITH AND WITHOUT CONTRAST
Accession Date: 11/11/2011 16:51
Dictated on : 11/12/2011 09:35
Attending MD: JORY D RICHMAN
Requesting MD: JORY D RICHMAN
Accession #: 65720569 Visit Number: 0334426881314
Attending Interpreter: KHURSHED J DASTUR
Assisting Interpreter:

*** FINAL REPORT ***

Reason for the Exam: MR1/DX: BACK PAIN

CLINICAL HISTORY:

Back pain. Status post surgery 06/30/11.

COMPARISON:

MRI lumbar spine 06/22/2011.

TECHNIQUE:

Multiplanar, multipulse images are obtained emphasizing T1 and T2-weighted imaging. Sagittal STIR images are also obtained. Examination is performed with and without the IV infusion of 14cc MultiHance.

FINDINGS:

There is again noted grade 1 degenerative anterolisthesis L4 on L5 with narrowing of the disc space. L5-S1 disc space is also slightly narrowed. Scout images reveal 5 lumbar vertebral bodies. The cerebellar tonsils are low-lying and could be evaluated further by MRI of brain if indicated.

At L5-S1 level: A right-sided laminectomy defect is noted. Enhancing post laminectomy scarring is noted extending into the right lateral aspect of the spinal canal and into the anterior epidural space. The scar tissue surrounds the right S1 root. The thecal sac is not displaced.

At L4-5 level: There is diffuse bulging of disc annulus and some unroofing of the disc. In addition, facetar degenerative changes are noted. There is narrowing of lateral recesses and central dimensions of the spinal canal. There is some inferior foraminal narrowing noted bilaterally. Exiting root shows no compression.

At L3-4 level: The disc contour is unremarkable and canal dimensions are normal.

At the L2-3 level: The disc contour is unremarkable and canal dimensions are normal.

<<< PAGE 1 >>>

*** RADIOLOGY REPORT ***

Patient Name: FONTANA, TRISH A DOB: 06/02/1967
MRN: 980404528 Gender: F Location: URAD (MCY)
Exam Desc: MR SPINE LUMBAR WITH AND WITHOUT CONTRAST

Accession Date: 11/11/2011 16:51
Dictated on : 11/12/2011 09:35

Attending MD: JORY D RICHMAN

Requesting MD: JORY D RICHMAN

Accession #: 65720569

Visit Number: 0334426881314

Attending Interpreter: KHURSHED J DASTUR

Assisting Interpreter:

At L1-2 level: There is some bulging of disc annulus. This is slightly eccentric to the left. Canal dimensions are normal.

The conus terminates at T12-L1 level and shows no compression. Signal of the conus appears normal.

IMPRESSION:

1. Right laminectomy at L5-S1 level. There is enhancing post laminectomy scarring extending into the right lateral aspect of the spinal canal and into the anterior epidural space. There is no definite nonenhancing tissue to suggest definite residual or recurrent disc protrusion. Scar tissue surrounds the right S1 root.
2. At L4-5 level, there is degenerative anterolisthesis of L4 on L5 with bulging and unroofing of the disc. There is central spinal stenosis at this level.
3. Some bulging of disc annulus noted at L1-2 level slightly eccentric to the left.

END OF IMPRESSION:

RELEVANT CLINICAL INFORMATION: MR1/DX: BACK PAIN

Dictated by: KHURSHED J DASTUR

Signed by: KHURSHED J DASTUR

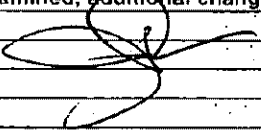
Signed on: 11/12/2011 at 09:35 AM

<<< PAGE 2 >>>

**PHYSICIAN HISTORY, PHYSICAL
ATTESTATION**

033442688-1179

IMPRINT PATIENT IDENTIFICATION HERE

DATE
H&P Review (*Must be completed by physician/surgeon the day of the procedure if H&P >24 hours and <30 days old)
<input checked="" type="checkbox"/> H&PE reviewed, patient examined, and there are no changes
<input type="checkbox"/> H&PE reviewed, patient examined, additional changes to the H & PE

Physician Signature:
Date:
Time:



1HP

Form ID: MER1010

Last Revision Date: 09/09

UPMC Mercy

PREOPERATIVE HISTORY AND PHYSICAL

Patient Name Trish Fontana
Surgical Procedure _____

HISTORY AND PHYSICAL MUST BE COMPLETED BY: PCP, SURGEON, OR DESIGNEE WITHIN 30 DAYS PRIOR TO THE SURGICAL PROCEDURE

PLEASE FAX COMPLETED H&P TO:

UPMC MERCY HOSPITAL PREADMISSION DEPARTMENT 412-232-7814

ENC #: 31791211

Name: FONTANA, TRISH ANN

MR#: 075677782 DOB: 6/02/1967

Dept: ORTHO MERCY OFC

Date: 6/27/11 Time: 9:00 AM

Prov: RICHMAN, JORY D

Ins:

Reason: herniated disc 01000075677782

Chief Complaint: LBPHistory Present Illness: PE has LBP since 4/6/11, severe pain + gradual worsening new difficulty w/ ADLs. Found to have HNP needing Surgery ☐ Over

Past Medical History/Past Surgical History:

5 children / 1 foot Surgery 2010 southsideLiver hemangiomas

Relevant Family History:

☒ Heart Disease☒ Hypertension☐ Cancer☒ Diabetes☐ Lungs☐ Other

Relevant Social History:

☐ Illicit drug use☒ Tobacco use☐ Alcohol use☐ Other:

Medications/Dosages/Frequency

1/2-1 PPD x 25yrsNone

Allergies

PCN 3 times Morphine - vomiting

Latex Allergy

☐ Yes☒ No

Explain if yes:

Review of Systems (pertinent comments):

Physical Examination:

BP

118/80

Pulse

100

Respiration

14

Temperature

Ø

Area	Normal	Abnormal	Detail of Findings
Skin	<input checked="" type="checkbox"/>		
Head/Neck	<input checked="" type="checkbox"/>		
ENT	<input checked="" type="checkbox"/>		
Eyes	<input checked="" type="checkbox"/>		
Heart	<input checked="" type="checkbox"/>		
Lungs	<input checked="" type="checkbox"/>		
Abdomen	<input checked="" type="checkbox"/>		
Extremities		<input checked="" type="checkbox"/>	<u>As Above</u>
Mental Status	<input checked="" type="checkbox"/>		
Neurological		<input checked="" type="checkbox"/>	<u>As Above</u>
Other			

IMPRESSION FOR PLANNED PROCEDURE:

OK for Surgery

PLEASE INDICATE ALL APPLICABLE PRE-TESTING HAS BEEN REVIEWED:

Authenticated by

Jory D. Richman, MD

On 07/07/2011 07:21:12 AM

CLINICAL STAFF SIGNATURE:

SIGNATURE:

D.O./M.D.

DATE 6/27/11

DATE

TIME: 7010

TIME:

☐ See Additional
Comments on
Reverse Side

H&P Review ("Must be completed by physician/surgeon the day of the procedure if above H&P >24 hours and <30 days old)

☐ H&PE reviewed, patient examined, and there are no changes☐ H&PE reviewed, patient examined, additional changes to the H & PE

Physician Signature

Date

Time



2HP

11010 (Created: 08/05; Revised: 09/09) Page

MRN: 980404528 06/30/11

FONTANA, TRISH ANN

033442688-1179 DOB: 06/02/67



Office Note - Outpatient

FONTANA, TRISH ANN - 075677782

* Preliminary Report *

Result Type: Office Note - Outpatient
 Performed Date: June 27, 2011 12:00 AM
 Result Status: Preliminary
 Result Title: OFFICE NOTE
 Performed By: RICHMAN, JORY D on June 27, 2011 9:51 AM
 Encounter info: OUTPT TRANSCRIPTION RESULT, - 1/1/2001

MRN: 980404528 06/30/11
 FONTANA, TRISH ANN
 033442688-1179 DOB: 06/02/67



* Preliminary Report *

OFFICE NOTE (Unverified)

SUBJECTIVE: Trish Fontana is a young woman referred from the emergency department for evaluation of spontaneous onset of lower back pain in the right side with severe sciatica in the right lower extremity that began 3 weeks ago. Her back pain has improved; however, her sciatica has not improved to any significant extent and follows an S1 dermatome.

PAST MEDICAL HISTORY: Unremarkable. She has no medical illnesses.

PHYSICAL EXAMINATION: She is a pleasant, normally developed, 44-year-old woman accompanied by her husband. She is standing as sitting causes a great deal of discomfort. She has a markedly positive straight-leg raising sign on the right side with an absent Achilles reflex, and diminished strength in her EHL on the right side as well.

DIAGNOSTIC TEST RESULTS: Review of an MRI scan reveals a large, extruded L5-S1 disk herniation on the right side consistent with her clinical symptoms.

ASSESSMENT AND PLAN: She has a large disk herniation, and we discussed the option of a microdiscectomy. The surgical risks were reviewed with her and her husband, including the risk of nerve injury, vascular injury, infection, CSF leak, and recurrence. All questions were answered, and surgery will be performed later this week.

Jory D. Richman, MD

D: 06/27/2011 09:51 AM (EST) T: 06/27/2011 10:04 AM (EST)
 DJN: 91711535
 SJN: 46958279
 180246

Printed by: SIMON, RHONDA
 Printed on: 6/27/2011 12:06 PM

Page 1 of 2
 (Continued)

REPORT 07/01/2011 18:52 PAGE 1
UPMC Mercy
1400 Locust Street
Pittsburgh, PA 15219
Name: FONTANA, TRISH ANN Ad.Date: 06/30/2011
Rm.Loc.: 11023-01 Med.Rec.No.: 980-40-4528
Dr.: Richman, Jerry D Acct.No.: 000334426881179
Age: 44Y Birth: 06/02/1967
Sex: F

***** Inorganic/Organic Analyses *****

DATE: 07/01/11
TIME: +0615 Reference Units
LOC: UDSC

Calcium	9.2	8.8-10.3	MG/DL
BUN	6	6-24	MG/DL
SODIUM	138	136-144	MMOL/L
POTASSIUM	4.3	3.5-4.9	MMOL/L
CHLORIDE	106	98-109	MMOL/L
CO2	25	22-32	MMOL/L
AGAP	7	4-12	MMOL/L
GLUCOSE, NF	H 127	70-99	MG/DL
CREATININE	0.62	0.50-1.17	MG/DL
	T24D1		
GFRAA	>59	>59	ML/MIN
GFROT	>59	>59	ML/MIN
GFRCM	CGFR		

---FOOTNOTES---

CGFR GFR IS ESTIMATED - CHRONIC KIDNEY DISEASE: <60 ML/MIN/1.73M2 - KIDNEY
FAILURE: <15 ML/MIN/1.17M2
T24D1 Creatinine standardized to reference material traceable to internationally
accepted Isotope Dilution Mass Spectrometry (IDMS) method.

UPMC Mercy Hospital Pittsburgh PA 15219

Data range flags: * = panic (critical) value

L=out of reference range low H=out of reference range high

@=out of reference range on non numeric result

PAGE: 1

REPORT 07/01/2011 18:52

PAGE 2

UPMC Mercy

1400 Locust Street

Pittsburgh, PA 15219

Name: FONTANA, TRISH ANN

Ad.Date: 06/30/2011

Rm.Loc.: 11023-01

Med.Rec.No.: 980-40-4528

Dr.: Richman, Jerry D

Acct.No.: 000334426881179

Age: 44Y Birth: 06/02/1967

Sex: F

***** CBC/Auto Diff *****

DATE: 07/01/11

TIME: +0615

ReferenceUnits

WBC	H 13.6	4.0-11.3	K/uL
RBC	L 3.33	4.10-5.10	M/uL
HGB	L 9.9	12.3-15.5	g/dL
HCT	L 28.9	36-45	%
MCV	87.0	80.0-100.0	fL
MCH	29.6	27.5-33.2	pg
MCHC	34.0	33.4-35.5	g/dL
RDW	H 15.6	11.5-15.0	%
PLT	278	150-450	K/uL
MPV	7.6	6.8-10.4	fL
NEUT%	H 91.8	42-75	%
LYMPH%	L 5.9	15-45	%
MONO%	2.3	0-12	%
EOS%	0.0	0-7	%
BASO%	0.0	0-2	%
ABS NEUT	H 12.5	1.8-7.9	K/uL
ABS LYMPH	L 0.8	1.0-4.0	K/uL
ABS MONO	0.3	0.2-1.0	K/uL
ABS EOS	0.0	0-0.7	K/uL
ABS BASO	0.0	0-0.2	K/uL

UPMC Mercy Hospital Pittsburgh PA 15219

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PAGE: 2

REPORT 07/01/2011 18:52

PAGE 3

UPMC Mercy

1400 Locust Street

Pittsburgh, PA 15219

Name: FONTANA, TRISH ANN

Ad.Date: 06/30/2011

Rm.Loc.: 11023-01

Med.Rec.No.: 980-40-4528

Dr.: Richman, Jerry D

Acct.No.: 000334426881179

Age: 44Y Birth: 06/02/1967

Sex: F

***** STAT ORDER APPENDIX *****

COLLECT

DATE	TIME	TEST NAME	CREDITED
06/22/11	1842	Basic Metabolic Panel	

UPMC Mercy Hospital Pittsburgh PA 15219

Data range flags: * = panic (critical) value

L=out of reference range low H=out of reference range high

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PAGE: 3

REPORT 07/02/2011 18:52

PAGE 1

UPMC Mercy

1400 Locust Street

Pittsburgh, PA 15219

Name: FONTANA, TRISH ANN

Ad.Date: 06/30/2011

Rm.Loc.: 11023-01

Med.Rec.No.: 980-40-4528

Dr.: Richman, Jerry D

Acct.No.: 000334426881179

Age: 44Y Birth: 06/02/1967

Sex: F

***** Inorganic/Organic Analyses *****

DATE: 07/01/11

TIME: 0615 Reference Units

LOC: UDSC

Calcium	9.2	8.8-10.3	MG/DL
BUN	5	6-24	MG/DL
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POTASSIUM	4.3	3.5-4.9	MMOL/L
CHLORIDE	106	98-109	MMOL/L
CO2	25	22-32	MMOL/L
AGAP	7	4-12	MMOL/L
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CREATININE	0.62	0.50-1.17	MG/DL
	T24D1		
GFRAA	>59	>59	ML/MIN
GFROT	>59	>59	ML/MIN
GFRCM	CGFR		

---FOOTNOTES---

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FAILURE: <15 ML/MIN/1.17M2

T24D1 Creatinine standardized to reference material traceable to internationally
accepted Isotope Dilution Mass Spectrometry (IDMS) method.

UPMC Mercy Hospital Pittsburgh PA 15219

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PAGE: 1

REPORT 07/02/2011 18:52

PAGE 2

UPMC Mercy

1400 Locust Street

Pittsburgh, PA 15219

Name: FONTANA, TRISH ANN

Ad.Date: 06/30/2011

Rm.Loc.: 11023-01

Med.Rec.No.: 980-40-4528

Dr.: Richman, Jerry D

Acct.No.: 000334426881179

Age: 44Y Birth: 06/02/1967

Sex: F

***** CBC/Auto Diff *****

DATE: 07/01/11

TIME: 0615

ReferenceUnits

WBC	H 13.6	4.0-11.3	K/uL
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BASO%	0.0	0-2	%
ABS NEUT	H 12.5	1.8-7.9	K/uL
ABS LYMPH	L 0.8	1.0-4.0	K/uL
ABS MONO	0.3	0.2-1.0	K/uL
ABS EOS	0.0	0-0.7	K/uL
ABS BASO	0.0	0-0.2	K/uL

***** CANCELLED TESTS *****

06/30/11 0725 CANCELLED: Type and Screen (Ind Coombs)

REASON:

UPMC Mercy Hospital Pittsburgh PA 15219

Data range flags: * = panic (critical) value

L=out of reference range low H=out of reference range high

REPORT 07/02/2011 18:52

PAGE 3

UPMC Mercy

1400 Locust Street

Pittsburgh, PA 15219

Name: FONTANA, TRISH ANN

Ad.Date: 06/30/2011

Rm.Loc.: 11023-01

Med.Rec.No.: 980-40-4528

Dr.: Richman, Jerry D

Acct.No.: 000334426881179

Age: 44Y Birth: 06/02/1967

Sex: F

@=out of reference range on non numeric result

PAGE: 2

REPORT 07/02/2011 18:52

PAGE 4

UPMC Mercy

1400 Locust Street

Pittsburgh, PA 15219

Name: FONTANA, TRISH ANN

Ad.Date: 06/30/2011

Rm.Loc.: 11023-01

Med.Rec.No.: 980-40-4528

Dr.: Richman, Jerry D

Acct.No.: 000334426881179

Age: 44Y Birth: 06/02/1967

Sex: F

***** STAT ORDER APPENDIX *****

COLLECT

DATE	TIME	TEST NAME	CREDITED
06/22/11	1842	Basic Metabolic Panel	

UPMC Mercy Hospital Pittsburgh PA 15219

Data range flags: * = panic (critical) value

L=out of reference range low H=out of reference range high

@=out of reference range on non numeric result

PAGE: 3

*** PATHOLOGY REPORT ***

Patient Name: FONTANA, TRISH ANN

DOB: 06/02/1967

MRN: 980404528

Gender: F

Location: U11E (MCY)

Specimen Class: MYSG

Accession Date: 06/30/2011 13:55

Collection Date: 06/30/2011 13:55

Attending MD: JORY RICHMAN

Requesting MD: JORY RICHMAN

Patient Type: (I) INPATIENT

Accession #: MYS11-6089

Visit Number: 0334426881179

*** FINAL REPORT ***

FINAL DIAGNOSIS:

DISC, L5-S1, DISCECTOMY:

TISSUE FROM DISC (GROSS DIAGNOSIS ONLY).

SEB/SEB

Pathologist: Yaoxian Ding, M.D.

** Report Electronically Signed Out **

By Pathologist: Yaoxian Ding, M.D.

7/1/2011 13:45

My signature is attestation that I have personally reviewed the submitted material(s) and the final diagnosis reflects that evaluation.

GROSS DESCRIPTION:

The specimen is received in saline and is labeled with the patient's name, initials TAF, and "disc". The specimen consists of a 2.0 X 1.0 X 0.8 cm. aggregate of pink-white, firm to rubbery tissue fragments. No obvious lesions are noted grossly. No sections are submitted. The specimen is submitted for gross examination only. MR/cbc

MLR//CBC/CBC

MICROSCOPIC:

No microscopic examination was performed on this specimen.

The following statement applies to all immunohistochemistry, Insitu Hybridization Assays (ISH & FISH), Molecular Anatomic Pathology, and Immunofluorescent Testing:

The testing was developed and its performance characteristics determined by the University of Pittsburgh, Department of Pathology, as required by the CLIA '88 regulations. The testing has not been cleared or approved for the specific use by the U.S. Food and Drug Administration, but the FDA has determined such approval is not necessary for clinical use.

This laboratory is certified under the Clinical Laboratory Improvement Amendments of 1988 ("CLIA") as qualified to perform high-complexity clinical

<<< PAGE 1 >>>

*** PATHOLOGY REPORT ***

Patient Name: FONTANA, TRISH ANN

DOB: 06/02/1967

MRN: 980404528

Gender: F

Location: U11E (MCY)

Specimen Class: MYSG

Accession Date: 06/30/2011 13:55

Collection Date: 06/30/2011 13:55

Attending MD: JORY RICHMAN

Requesting MD: JORY RICHMAN

Patient Type: (I) INPATIENT

Accession #: MYS11-6089

Visit Number: 0334426881179

testing. Pursuant to the requirements of CLIA, ASR's used in this laboratory have been established and verified for accuracy and precision. Additional information about this type of test is available upon request.

PATIENT HISTORY:

Herniated nucleus pulposus, L5-S1.

Pre-Op Diagnosis: Herniated nucleus pulposus, L5-S1.

Post-Op Diagnosis: Herniated nucleus pulposus, L5-S1.

TC1

<<< PAGE 2 >>>

*** RADIOLOGY REPORT ***

Patient Name: FONTANA, TRISH ANN DOB: 06/02/1967
MRN: 980404528 Gender: F Location: USUR (MCY)
Exam Desc: XRAY SPINE ONE VIEW

Accession Date: 06/30/2011 12:52
Dictated on : 06/30/2011 14:01

Attending MD: JORY D RICHMAN

Requesting MD: JORY D RICHMAN

Accession #: 64627331

Visit Number: 0334426881179

Attending Interpreter: BEATRICE A CARLIN

Assisting Interpreter:

*** FINAL REPORT ***

Reason for the Exam: LUMBAR DISC DISPLACEMENT

CLINICAL HISTORY:

Intraoperative evaluation.

COMPARISON:

MRI of the lumbar spine performed on 06/22/2011.

FINDINGS:

A metallic marker is present at the posterior aspect of the lumbar spine at the L5-S1 level.

END OF IMPRESSION:

RELEVANT CLINICAL INFORMATION: LUMBAR DISC DISPLACEMENT

Dictated by: BEATRICE A CARLIN

Signed by: BEATRICE A CARLIN

Signed on: 06/30/2011 at 2:01 PM

<<< PAGE 1 >>>

*U*P*M*C* FONTANA, TRISH Acct#:0334426881179

UPMC MERCY
ORTHOPAEDICS
OPERATIVE REPORT

PATIENT NAME: FONTANA, TRISH A
ACCOUNT #: 0334426881179
SURGEON: Jory D. Richman, M.D.
ATTENDING PHYSICIAN: JORY D RICHMAN
SURGERY DATE: 06/30/11
ADMISSION DATE: 06/30/2011
DISCHARGE DATE:

PREOPERATIVE DIAGNOSIS:

HERNIATED NUCLEUS PULPOSUS, L5-S1, RIGHT SIDE.

POSTOPERATIVE DIAGNOSIS:

HERNIATED NUCLEUS PULPOSUS, L5-S1, RIGHT SIDE.

PROCEDURE PERFORMED:

MICRODISKECTOMY, L5-S1, RIGHT SIDE.

ASSISTANT:

Geoffrey D. Cornelsen, D.O.

ANESTHESIA:

General.

INDICATION:

This patient is a 44-year-old woman with L5-S1 disk herniation causing significant compression of the right S1 nerve root. She has elected to undergo a microdiscectomy. The surgical risks were discussed with her including the risk of recurrence, vascular injury, infection, nerve damage, and CSF leak. She understands the surgical risks and wishes to proceed.

DESCRIPTION OF PROCEDURE:

Following the induction of general anesthesia, she was positioned prone on a Kambin frame, and her lumbar area was prepped and draped in a sterile fashion. A 3 cm incision was made at the L5-S1 interspace. The fascia was incised, and an intraoperative x-ray was taken to confirm localization.

Under an operating microscope, a small laminotomy was performed at L5-S1 and the S1 nerve root was identified. There was an extremely large extruded disk herniation that had migrated proximally and this was removed with a pituitary rongeur. The annulus was explored by making a longitudinal separation and some additional nuclear material was removed. However, the majority of the

*U*P*M*C* FONTANA, TRISH Acct#:0334426881179

compression came from the large extruded fragment. Following this diskectomy and a Valsalva maneuver was performed, and there was no evidence of CSF leak. The wound was irrigated and 80 mg of Depo-Medrol was instilled over the laminotomy site. The deep fascia was closed with 0 Polysorb suture. The subcutaneous tissue was closed with 2-0 Polysorb suture, and the skin was closed with a running subcuticular 4-0 Monocryl suture and Dermabond. A sterile dressing was applied, and she was transferred to the Recovery Room in good condition.

Authenticated electronically at end of document

Dictator: Jory D. Richman, M.D.

JDR/za

D: 06/30/2011 13:19:54

T: 06/30/2011 22:01:48

R: 06/30/2011 22:01:48/za

40454484/3459093/37053268

CC:

Authenticated by Jory D. Richman, MD On 07/07/2011 07:21:03 AM

*** RADIOLOGY REPORT ***

Patient Name: FONTANA, TRISH ANN DOB: 06/02/1967
MRN: 980404528 Gender: F Location: UOUT (MCY)
Exam Desc: XRAY CHEST FRONTAL AND LATERAL VIEWS

Accession Date: 06/27/2011 10:35
Dictated on : 06/27/2011 12:28

Attending MD: JORY D RICHMAN

Requesting MD: JORY D RICHMAN

Accession #: 64595013

Visit Number: 0334426881178

Attending Interpreter: E. ROBERT GATES

Assisting Interpreter:

*** FINAL REPORT ***

Reason for the Exam: PRE OP/BACK SX

CLINICAL HISTORY:
Preoperative examination.

TECHNIQUE:
Two views were obtained.

FINDINGS:
The heart is normal in size and the lungs are clear. There are no
pleural or mediastinal lesions.

IMPRESSION:

Normal heart size and clear lungs without change since a prior
examination dated 06/07/2010.

END OF IMPRESSION:

RELEVANT CLINICAL INFORMATION: PRE OP/BACK SX

Dictated by: E. ROBERT GATES

Signed by: E. ROBERT GATES

Signed on: 06/27/2011 at 12:28 PM

<<< PAGE 1 >>>

*U*P*M*C* FONTANA, TRISH Acct#:0334426881173

UPMC MERCY
EMERGENCY DEPARTMENT EVALUATION

PATIENT NAME: FONTANA, TRISH A
ACCOUNT #: 0334426881173
DATE OF SERVICE: 06/22/2011

CHIEF COMPLAINT: Worsening back pain, right leg numbness

HISTORY OF PRESENT ILLNESS: 44-year-old female who developed spontaneous right-sided low back pain accompanied by a right lower extremity numbness about 2-1/2 weeks ago. There was no recall of any trauma or change in activities prior to the initial pain initiation. The patient was seen several times by a chiropractor with no relief. She then subsequently came to the emergency department about 3 days ago and was evaluated and felt to have sciatica. She was referred to orthopedics however has not been able to get an appointment so far. The patient's complaint of pain as well as some subjective weakness of the right lower extremity and numbness has worsened. She has numbness that goes from the buttocks around the lateral thigh and into the heel and forefoot. The patient denies any urinary or bowel symptoms other than mild constipation since starting the medications prescribed at her last visit. There is no clear perineal numbness however it feels somewhat unusual for the patient's report. There is no history of fever. There is no infectious episode prior to onset. She does have a history hemangiomas in the liver.

REVIEW OF SYSTEMS: All systems listed below were reviewed and are negative unless otherwise noted in the report.

General no fever no recent illness

EYES

ENT

Cardiac

Respiratory

Gastrointestinal no abdominal pain no fecal incontinence. Some constipation since starting Percocet

Genitourinary no urinary frequency urgency or retention

Musculoskeletal

Dermatologic no skin rash

Neurological

PAST MEDICAL HISTORY: See Chart history of liver hemangiomas, ankle fracture. No diabetes, hypertension

MEDICATIONS: Reviewed and agree with nurses notes Percocet ibuprofen

ALLERGIES: Reviewed and agree with nurses notes morphine-vomiting

SOCIAL HISTORY: See Chart

PHYSICAL EXAM: Vital Signs reviewed nurses' note afebrile. Vital signs stable

PATENT STATUS: alert and comfortable

*U*P*M*C* FONTANA, TRISH Acct#:0334426881173

HEAD: atraumatic, normocephalic

EYES: PERRL, EOMI. No conjunctival injection or exudate

THROAT: Airway Patent. Mucous membrane pink and moist. No oral mucosal lesions. No pharyngeal inflammation, exudate or tonsillar hypertrophy.

NECK: Supple with FROM. No palpation tenderness or lymphadenopathy.

LUNGS: Respirations unlabored with good air entry bilaterally. Breath sounds clear without stridor, wheezing or crackles.

HEART: Regular rate and rhythm. No murmur, gallop or rub.

Back: There is reproducible tenderness both the midline in the paralumbar regions in the mid to upper lumbar back. There is pain with range of motion. There is no erythema, warmth or redness overlying the spine

ABDOMEN: Non-distended with active bowel sounds. No tenderness, rebound or guarding. No hepatosplenomegaly or mass.

SKIN: Warm, dry, without rashes

MUSCULOSKELETAL: Extremities are symmetrical, FROM, without tenderness or edema distal pulses are intact.

NEUROLOGICAL: Alert and oriented. Cranial nerves intact. Motor and sensory functions intact with the exception of a decreased sensation in the right lateral foot, right lateral calf and thigh.

Deep tendon reflexes are 2+ at the left patella and ankle jerks, 1+ at the right patella and difficult to elicit at the right ankle jerk.

Motor strength in the foot extensor on the right seems to be slightly decreased although this may partially related pain

DIAGNOSTIC STUDIES: MRI: as read by radiology there is a large right-sided disc herniation at the L5-S1 interspace with a free fragment.

HOSPITAL COURSE/ Medical decision-making: an intravenous was placed in the patient was treated with Dilaudid 1 mg for pain. She was also given a dose of Decadron for anti-inflammatory affect. Given the findings on exam an MRI is the most appropriate test at this point. Possible given the worsening of symptoms and that demonstrated findings we will attempt to obtain this today from the emergency department.

The patient maintain good pain control. She was a note Torre in emergency department without significant problems.

Re-examination: There continues to be some minor decrease in extension of the right great toe as well as a decrease in the right ankle jerk reflex.

The covering physician for Dr Richman was contacted they agree with the initial dose of steroids but did not opt for any further steroids. the patient was advised to contact the office tomorrow for possibility of accelerating her appointment.

Given a continued improvement in her pain and keeping with the patient's wishes she was discharged home to continue with her pain control regimen. Short term she has any further worsening of symptoms prior to being evaluated by the orthopedic service.

DIAGNOSIS: L5 S1 herniated disc, right lumbar radiculopathy

DISPOSITION:

The patient was discharged home in stable condition. A customized computer generated instruction sheet was given and a copy is attached to the chart.

*U*P*M*C* FONTANA, TRISH Acct#:0334426881173

Note Initiated by: John Murray, M.D.

D: 06/22/2011 22:35:17
40334066/36932474

Document authenticated by:John Murray, M.D., on 06/22/2011 22:35:19.

REPORT 06/23/2011 18:59

PAGE 1

UPMC Mercy

1400 Locust Street

Pittsburgh, PA 15219

Name: FONTANA, TRISH ANN

Ad.Date: 06/22/2011

Loc.: UDEM

Med.Rec.No.: 980-40-4528

Dr.: Whiteford, John Ryan

Acct.No.: 000334426881173

Age: 44Y Birth: 06/02/1967

Sex: F

***** Inorganic/Organic Analyses *****

DATE: 06/22/11

TIME: +1842

Reference Units

LOC: UDEM

Calcium	9.7	8.8-10.3	MG/DL
BUN	8	6-24	MG/DL
SODIUM	138	136-144	MMOL/L
POTASSIUM	3.7	3.5-4.9	MMOL/L
CHLORIDE	106	98-109	MMOL/L
CO2	25	22-32	MMOL/L
AGAP	7	4-12	MMOL/L
GLUCOSE, NF	93	70-99	MG/DL
CREATININE	0.69	0.50-1.17	MG/DL
	T24D1		
GFRAA	>59	>59	ML/MIN
GFROT	>59	>59	ML/MIN
GFRCM	CGFR		

---FOOTNOTES---

CGFR GFR IS ESTIMATED - CHRONIC KIDNEY DISEASE: <60 ML/MIN/1.73M2 - KIDNEY
FAILURE: <15 ML/MIN/1.17M2

T24D1 Creatinine standardized to reference material traceable to internationally
accepted Isotope Dilution Mass Spectrometry (IDMS) method.

UPMC Mercy Hospital Pittsburgh PA 15219

Data range flags: * = panic (critical) value

L=out of reference range low H=out of reference range high

@=out of reference range on non numeric result

PAGE: 1

REPORT 06/23/2011 18:59

PAGE 2

UPMC Mercy

1400 Locust Street

Pittsburgh, PA 15219

Name: FONTANA, TRISH ANN

Ad.Date: 06/22/2011

Loc.: UDEM

Med.Rec.No.: 980-40-4528

Dr.: Whiteford, John Ryan

Acct.No.: 000334426881173

Age: 44Y Birth: 06/02/1967

Sex: F

***** STAT ORDER APPENDIX *****

COLLECT

DATE	TIME	TEST NAME	CREDITED
06/22/11	1842	Basic Metabolic Panel	

UPMC Mercy Hospital Pittsburgh PA 15219

Data range flags: * = panic (critical) value

L=out of reference range low H=out of reference range high

@=out of reference range on non numeric result

PAGE: 2

*** RADIOLOGY REPORT ***

Patient Name: FONTANA, TRISH ANN DOB: 06/02/1967
MRN: 980404528 Gender: F Location: UDEM (MCY)
Exam Desc: MR SPINE LUMBAR WITHOUT CONTRAST

Accession Date: 06/22/2011 21:07
Dictated on : 06/22/2011 21:59

Attending MD: JOHN R WHITEFORD

Requesting MD: JOHN MARTIN MURRAY

Accession #: 64565911

Visit Number: 0334426881173

Attending Interpreter: BARTON F BRANSTETTER

Assisting Interpreter:

*** FINAL REPORT ***

Reason for the Exam: progressive back pain, left leg numbness and decreased refl

CLINICAL HISTORY:

Back pain, paresthesias, and diminished reflexes.

TECHNIQUE:

Sagittal and axial short and long TR images were obtained through the lumbar spine.

COMPARISON:

None.

FINDINGS:

The overall alignment of the lumbar spine is preserved. No bone marrow signal abnormalities are seen. The spinal cord is normal in signal and terminates at a normal level.

At L4-5, there is a diffuse disc bulge with overlying central disc herniation that causes moderate left lateral recess stenosis. No foraminal stenosis results.

At L5-S1, there is a large right paracentral and lateral disc herniation that completely occludes the lateral recess and severely stenosis of the neural foramen. There is a free fragment of disc that is migrated slightly cranially behind the L5 vertebral body. The L5 nerve root as it exits is engorged, and edematous.

IMPRESSION:

There is huge right-sided disc herniation with a free fragment at L5-S1. There is lateral recess stenosis at the left at L4-5.

END OF IMPRESSION:

RELEVANT CLINICAL INFORMATION: progressive back pain, left leg numbness and decr

Dictated by: BARTON F BRANSTETTER

Signed by: BARTON F BRANSTETTER

Signed on: 06/22/2011 at 9:59 PM

<<< PAGE 1 >>>

*U*P*M*C* FONTANA, TRISH Acct#:0334426881170

UPMC MERCY
EMERGENCY DEPARTMENT EVALUATION

PATIENT NAME: FONTANA, TRISH A
ACCOUNT #: 0334426881170
DATE OF SERVICE: 06/19/2011

CHIEF COMPLAINT: Back Pain

HISTORY OF PRESENT ILLNESS: The patient presents with a 2 weeks history of right lumbosacral back pain. The pain began without provocation.. The pain is described as severe, sharp and is radiating into the right leg.. The pain is made worse with movement The patient the patient describes paresthesias intermittently over the right lateral calf but denies any weakness or bowel or bladder difficulty. The patient also denies abdominal, dysuria, frequency or flank pain Home treatment has been NSAID's. She has been seeing a chiropractor without relief of symptoms.

REVIEW OF SYSTEMS: All systems listed below were reviewed and are negative unless otherwise noted in the report.

General
Gastrointestinal
Genitourinary
Musculoskeletal
Neurological

PAST MEDICAL HISTORY: See HPI achilles tendonitis; Bronchitis, acute; GERD

MEDICATIONS: Reviewed and agree with nurses notes

ALLERGIES: Reviewed and agree with nurses notes

FAMILY MEDICAL HISTORY:

SOCIAL HISTORY: In speaking

PHYSICAL EXAM: Vital Signs: Reviewed and agree with nurses notes

PATENT STATUS: alert and comfortable

BACK: Paravertebral lumbosacral tenderness to palpation without swelling or discoloration.

MUSCULOSKELETAL: Extremities are symmetrical, FROM, without swelling or tenderness

NEUROLOGICAL: Motor and sensory examination of the lower extremities intact. Knee and ankle reflexes normal.

DIAGNOSTIC STUDIES:

HOSPITAL COURSE:

*U*P*M*C* FONTANA, TRISH Acct#:0334426881170

MEDICAL DECISION MAKING: The patients clinical presentation is consistent with lumbar sciatica No clinical evidence of myelopathy, or cauda equine syndrome. We are treating the patient symptomatically with NSAIDS and a limited supply of oral opiates. We have recommended follow up with Dr. Richman for further evaluation and treatment.. The patient knows to return promptly for new or worsening symptoms.

DIAGNOSIS: Lumbar radiculopathy

DISPOSITION: The patient was discharged home in stable condition. A customized computer generated instruction sheet was given and a copy is attached to the chart.

Note Initiated by: Bruce W. Rosenthal, MD

D: 06/22/2011 09:20:11
40316922/36922909

Document authenticated by: Bruce W. Rosenthal, MD, on 06/22/2011 09:20:13.

*** RADIOLOGY REPORT ***

Patient Name: FONTANA, TRISH ANN DOB: 06/02/1967
MRN: 980404528 Gender: F Location: JPAT (MCY)
Exam Desc: CHEST FRONTAL AND LATERAL VIEWS

Accession Date: 06/07/2010 10:24
Dictated on : 06/07/2010 10:34

Attending MD: JAMES N DEANGELO

Requesting MD: JAMES N DEANGELO

Accession #: 61588953

Visit Number: 0334426880158

Attending Interpreter: STEVEN P KARR

Assisting Interpreter:

*** FINAL REPORT ***

Reason for the Exam: COUGH, WHEEZING, SOB

EXAMINATION PERFORMED:

CHEST FRONTAL AND LATERAL VIEWS 06/07/10 1014 HOURS

CLINICAL HISTORY:

Cough and wheezing.

TECHNIQUE:

PA and lateral views

FINDINGS:

The lungs, cardiovascular silhouette and pulmonary vasculature are normal. No pleural changes or osseous abnormalities are seen.

IMPRESSION:

NORMAL CHEST.

END OF IMPRESSION:

RELEVANT CLINICAL INFORMATION: COUGH, WHEEZING, SOB

<<< Page 1 >>>

03/29/10 08:24 AM BRENTWOOD MEDICAL GROUP Acct#: 13626
 Trishann Fontana DOB: 06/02/1967 Sex: F Age: 42 years
 Page 2 of 3 #98100

03/29/10 BRENTWOOD MEDICAL GROUP Acct#: 13626
 Trishann Fontana DOB: 06/02/1967 Sex: F Age: 42 years
 Nurse Note: CC: PRE-OP SURG 4-7-10 - DR. DAVID MANCE (FAX 412-881-1026)

Subjective

CC: Patient presents for preoperative visit.
 HPI: Presents for consultation and pre-op clearance exam.
 Pre-op clearance exam: Surgeon: Dr David Mance

ROS:

Const: Denies constitutional symptoms.

ENMT: Denies ear symptoms.

Resp: Denies respiratory symptoms.

Musculo: Reports foot pain.

Surgical Risk Factors:

Hx of blood dyscrasias or easy bleeding? no

Hx of untoward anesthetic reaction? no

Hx of recent steroid use? no

Hx of diabetes? no

Hx of hypertension? no

Hx of laryngeal or tracheal damage? no

Hx of cervical spine pain/fracture/surgery? no

Hx of reaction to iodine or tape or latex? no

Hx of transfusions? no

Use of contacts? no

Use of dentures/partial dentures? no

Current Meds: Ibuprofen 800 mg, Pirosec 20 mg, Proair HFA 108 (90 Base) mcg/ac, Zyrtec Allergy 10 mg, Omnicor 50 mcg/Act, Pataday 0.2 %

Allergies: Penicillin, Morphine, Pentothal

PMH:

Medical Problems:

None

Surgical Hx:

None

Reviewed, no changes.

FH:

Reviewed, no changes.

SH:

Personal Habits: Cigarette Use: Current Cigarette Smoker 1 Pack Daily. Alcohol: Denies alcohol use.

Reviewed, no changes.

Objective:

Wt: 155lb Wt Prior: 143lb as of 03/08/10 Wt Diff: +12lb Ht: 63.25" 5'3.25" BP: 120/70 T: 98.5

Pulse: 78 BMI: 27.2 IBW: 115

Exam:

03/29/10 09:24 AM medent via VSI-FAX Fox#

Page 3 of 3 - 30400

Trishann Fontana DOB 06/02/1967

Page #2

Const: Appears healthy and well developed. No signs of acute distress present. Alert and oriented.

Head/Face: Normal on inspection.

Eyes: Conjunctivae clear. PERRL. Sclerae are anicteric.

ENMT: External ears WNL. Oropharynx: Appears normal.

Neck: No JVD. Carotids: 2+ and equal bilaterally, without bruits.

Resp: AP diameter is unremarkable. Clear to auscultation.

CV: Rate is regular. Rhythm is regular. S1 is normal. S2 is normal. No heart murmur appreciated. No extra sounds. Pedal pulses: 2+ and equal bilaterally. Extremities: Peripheral circulation is grossly normal. No edema of the lower limbs bilaterally.

Abdomen: Positive bowel sounds. No bruits. Normal to percussion. Abdomen is soft, nontender, and nondistended without guarding, rigidity or rebound tenderness. No abdominal masses. No pulsatile masses present. No palpable hepatosplenomegaly.

Lymph: No palpable or visible regional lymphadenopathy.

Assessment #1: V72.83 Examination Preoperative Other Spec
Comments : NO CONTRAINDICATION FOR SURGERY
Plan:
Lab : BMP Basic Metabolic Panel
CBC W/Diff & PLT

Assessment #2: 729.5 Pain In Limb
Plan:
Follow Up : (Follow up)

Seen By:



03/29/2010 9:22 am

Authenticated by
David J Mance
On 04/15/2010 11:56:09 AM

Trishann Fontana DOB 06/02/1967

Page #2

*U*P*M*C* FONTANA, TRISH Acct#:0334426880082

UPMC MERCY AT SOUTH SIDE OUTPATIENT CENTER
Podiatry
Same Day Surgery Operative Report

PATIENT NAME: FONTANA, TRISH A
ACCOUNT #: 0334426880082
SURGEON: David J. Mance, D.P.M.
SURGERY DATE: 04/07/10

TITLE OF OPERATION:

LEFT ANKLE ARTHROSCOPIC DEBRIDEMENT.

ANESTHESIA:

LOCAL WITH MAC USING 25 mL OF 1% LIDOCAINE (PLAIN).

PREOPERATIVE DIAGNOSIS:

LEFT ANKLE ARTHRITIS AND SYNOVITIS.

POSTOPERATIVE DIAGNOSIS:

LEFT ANKLE ARTHRITIS AND SYNOVITIS.

SURGEON:

David J. Mance, D.P.M.

ASSISTANT:

Joseph Yeargain, D.P.M.

HEMOSTASIS:

Left calf pneumatic tourniquet.

ESTIMATED BLOOD LOSS:

Less than 15 mL.

MATERIALS:

Nylon suture.

INDICATIONS:

The patient was seen in Dr. Mance's office complaining of severe pain to the anterolateral ankle gutter. Radiographs confirmed a decrease in joint space, and clinical exam confirms pain with range of motion and palpation to the anterolateral gutter. A diagnostic joint injection was performed relieving the patient's symptoms. Therefore, it was deemed necessary to undergo arthroscopic

*U*P*M*C* FONTANA, TRISH Acct#:0334426880082
surgical debridement of the left ankle joint.

DESCRIPTION OF OPERATION:

The patient was identified in the preoperative holding area. Formal consent was signed, including: all risks, benefits, complications, and alternatives of the procedure. The correct operative site was marked as the left lower extremity. The patient was in full agreement with the treatment plan.

Next, the patient was brought into the Operating Room and placed on the table in a supine position. A pneumatic left calf tourniquet was placed. The first time-out was performed, including: the patient's full name, medical record number, correct operative site, and any allergies.

Next, the area was scrubbed, prepped, and draped in the usual, aseptic manner. 25 mL of 1% lidocaine (plain) was used in an ankle block fashion. IV sedation was performed.

Next, attention was directed to the left ankle where two stab incisions were made in a typical anterolateral and anteromedial ankle scope portals. These were deepened down to the capsule layer using a curved hemostat, and using a blunt obturator with a cannula, the instrumentation was inserted into the portals. A 4.0 arthroscope was used as well as a soft-tissue shaver in order to debride extensive synovitis from the anterior portion of the lateral and medial ankle gutters with severe synovitis noted to the anterolateral ankle _____. Following debridement, the ankle scope was clear, and there were no osteochondral defects noted. Excellent range of motion was maintained. There were no osteophyte formations on the anterior tibial, and no adhesions were noted. No vastus lesion was identified.

Next, copious lavage was performed to the left ankle joint using lactated Ringer's, and the portals were closed with horizontal-mattress sutures using nylon 3-0. A sterile compressive dressing was in place to the ankle joint using 4 x 4s, Kerlix, and an Ace bandage. The tourniquet was deflated, and a prompt hyperemic response was noted to the left foot.

The patient tolerated the procedure and anesthesia well and was transferred to the PACU with vital signs stable and vascular status intact to the left foot.

The patient will be given a prescription for Percocet 5/500 (#30) to be taken one every four-to-six hours, as needed, for pain. She will be made weightbearing, as tolerated, to the left lower extremity using a postoperative shoe and crutches, as needed. She will follow up with Dr. Mance in one week.

ATTESTATION STATEMENT:

Dr. Mance was present for the entire case.

David J. Mance, D.P.M.

DICTATED BY: Joseph Yeargain, D.P.M.

*U*P*M*C* FONTANA, TRISH Acct#:0334426880082

JY/kmk

D: 04/07/2010 09:07:09
T: 04/07/2010 13:33:58
R: 04/07/2010 13:33:58/kmk
31845184/2575885/29240647

CC:

Authenticated by David J Mance On 04/15/2010 11:56:02 AM

UPMC

Health Information Management
Release of Information Department
Melwood Building – Lower Level
200 Lothrop Street
Pittsburgh, PA 15213

INVOICE

Date May 18, 2013
Request # 246262

BILL TO:
Bureau of Disability
S67 Greensburg/PA-DDS P O Box 8751
London KY 40742

Patient Name	Medical Record/Soc Security #	UPMC Facility
FONTANA, TRISH A	980404528	Mercy (MCY)
Total Pages Released		39
Balance Due		\$26.12

Dear Requestor:

This letter is to inform you that the Health Information Management, Release of Information Department for UPMC Mercy Hospital has received your request for release of medical record information on the above referenced patient(s). Enclosed are the medical records that you have requested.

Payments

Please make check or money order payable to UPMC Mercy Hospital and be sure to include this invoice along with the payment. All payments are to be sent to the UPMC address at the top of this letter. For your records, our tax id number is 25-0965429. If you would like to make a payment via credit card, log onto the following website and choose "Medical Record" as the Type of Bill. Information from your invoice will be needed. <https://npaybill.upmc.com>

Films and Photographs

Please note that a request for a complete medical record will not include photographic or radiographic images. Photographs will need to be specifically requested on the authorization. Radiology images will need to be requested from the appropriate radiology department located in the hospital at which the patient was seen.

Questions/Canceling Requests

If records are no longer needed or you wish to cancel this request for any reason, please notify the Release of Information Department so that the balance can be removed from your name. All cancellations and any questions related to this invoice can be directed to the Release of Information Department at 412-802-0100, Monday – Friday, 8:00am – 5:00pm.

DISCLOSURE STATEMENTS:

This information has been disclosed to you from records whose confidentiality is protected by state and federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

This information has been disclosed to you from records whose confidentiality is protected by State statute. State regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains. This information has been disclosed to you from records that may be protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. This information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

The paper copy of an electronic record can vary in format and content, depending on how or when the record was printed. If there are questions as to the format or content of the electronic chart, please contact us at the number above.

The paper copy of the electronic anesthesia record may contain truncated data. If the banner bar of the anesthesia record contains the statement "Actions – Refer to the electronic record for complete data", please contact us at the number above if the complete anesthesia record is needed.